Longfield (Care Homes) Limited

Longfield Residential Home - MD

Inspection report

Longfield
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Longfield Residential Home – MD is a residential care home providing personal care to 11 people aged 65 and over at the time of the inspection. The service can support up to 24 people. The service specialises in caring for people living with dementia. The service is in a residential area close to Blackburn town centre and local amenities.

People's experience of using this service and what we found
We found significant safeguarding concerns and avoidable harm had occurred within the home. Risks to people's health and safety were not always assessed and managed and accident and incident records were not always completed or completed in full.

Infection control systems and processes were not always safe. Staff were seen on several occasions not wearing masks correctly and correct personal protective equipment (PPE) was not always available in PPE stations. The manager had not ensured Government guidance was being followed regarding temperature checks and vaccination status of agency staff. There was continued risk of head lice transmission within the home. Clean towels were being stored in a toilet area and a communal bathroom was being used as a sluice area for commodes.

Systems and processes in place did not protect people from the risk of abuse. Monitoring systems put in place by the manager were not being followed by staff; the manager was unaware of this. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. For example, the manager had segregated two people in a separate area of the home until advised not to do this by the local safeguarding team.

The service was not caring, and people were not treated with dignity and respect. People using the service had clothing not belonging to them, clothing was not neatly folded in drawers, some people had no underwear and some underwear was in a poor state. People appeared as though their hair had not been brushed. One relative spoke of being 'shocked' at their family member's presentation and another relative told us "Mum's hygiene is shocking."

The provider's systems to assess, monitor and improve the quality of the service had not identified the concerns and shortfalls highlighted in this report. There was a lack of oversight by the manager who was unaware of several of the issues we found on inspection. The service did not promote a positive culture and people did not achieve good outcomes, which is evidenced throughout this report. When one staff was asked if they would be happy for their family member to live in the service, they told us, "Not a chance."

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)

The last rating for this service was inadequate (published 6 November 2021) and there were multiple breaches of regulation. At this inspection we found insufficient improvements had been made and the provider remained in breach of the regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the safeguarding of vulnerable people and continued concerns about a lack of improvement in the care and treatment of people using the service. A decision was made for us to inspect and examine those risks.

We also undertook this focused inspection to check whether the Warning Notices we previously served in relation to Regulation 10, Regulation 12, Regulation 17 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this focused inspection and remains inadequate.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Longfield Residential Home - MD

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This was a focused inspection due to concerns raised by the local authority safeguarding team and to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 10 (Dignity and Respect), Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of this inspection we also looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors on each day.

Service and service type
Longfield Residential Home - MD is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with three relatives about their experience of the care provided. We spoke with nine members of staff including the manager, senior care workers, care workers, a chef, a housekeeper and an activities co-ordinator.

We reviewed a range of records. This included five people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. However, we did not receive all the evidence requested on a number of occasions. We continued to liaise with the local safeguarding team and local authority to ensure people using the service were safe.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure adequate management of risks to people using the service. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● We found significant safeguarding concerns and avoidable harm had occurred. We found instances of abuse had occurred within the home on several occasions and people had experienced avoidable harm. Agency staff had not received enough information about people's needs to help them protect vulnerable people. For example, one agency staff we spoke with was unaware of the risks of abuse and how this was being monitored.
● Risks to people's health and safety were not always assessed and managed. For example, people were at continued risk of losing weight as some staff were incorrectly recording nutritional intake, and risk assessments and care plans were not always reflective of support being given. One staff member told us, "Care plans are not always accurate and are changed to suit management."
● During a tour of the home, we found toiletries such as Steradent (a product used to clean false teeth), shower gels and prescribed creams accessible in people's bedrooms. Risk assessments were not in place for these despite all people using the service living with some degree of dementia.
● Accident and incident records were not always completed or completed in full. For example, safeguarding incidents had not been documented on incident forms, accident forms were not always completed in full and post fall forms and checks were not always completed. One accident form recorded there was no injury however, the body map showed there was a skin tear to the elbow. This meant opportunities to learn lessons from incidents may have been missed.

The provider had failed to ensure adequate management of risks to people using the service to ensure avoidable harm did not occur. This is a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to ensure people using the service were protected from the risk of infections. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● During the tour of the building, we found Personal Protective Equipment (PPE) stations were not always adequately stocked. For example, one identified area had no gloves; the same area we previously found was inadequately stocked. Staff were not always wearing PPE correctly. For example, we observed staff with masks under their chin and under their nose on both days of the inspection. We also observed one staff member walk into the home, through communal areas and into the office before putting on a mask. When we mentioned this to a senior member of staff they commented, "It is not like they don't get told every day." Another staff member told us, "People are not protected as staff are not wearing PPE correctly." A relative who had recently visited the service told us, "Two staff supporting (family member) were not wearing a mask."
● The manager had not ensured Government guidance was being followed regarding temperature checks for people using the service.
● The home had documented several outbreaks of head lice. Whilst people had their own, named hairbrushes, we observed a staff member washing and blow-drying people's hair using the same hairbrush. The manager told us people's hair was checked for head lice every three days however, records showed this was to be done every morning.
● The laundry and sluice area were not suitable for use and therefore other areas of the home were being inappropriately used. For example, we observed clean towels were being stored in a toilet used by staff and commodes were being soaked in a communal bathroom which staff told us was accessed by one person using the service.
● We found several bins within the home were not suitable. For example, did not have a lid, broken foot pedals or not foot operated.

The provider had failed to ensure people using the service were protected from the risk of infections. This is a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager was able to provide records to evidence they had checked the vaccination status of staff and external professional's entering the home. However, they were unable to provide records to evidence they had checked the vaccination status of agency staff entering the home.

We found no evidence that people had been harmed however, the provider had failed to evidence they had checked the vaccination status of agency staff. This is a breach of Regulation 12 (3) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The systems and processes in place within the home did not protect people from the risk of abuse. We found evidence that avoidable harm had occurred on a number of occasions within the home. We asked the provider and manager to provide us with further information on this on two separate occasions. We were not sent this information. We found monitoring systems put in place by the manager were not being followed by staff. The manager was unaware of this until we informed them during the inspection. One staff member told us, "People are not 100% safe."
● We found the manager had restricted some people using the service by segregating them into separate areas of the home. The manager told us they had ceased this restriction when advised to do so by the local

safeguarding team.
● The provider and manager had not notified us of these safeguarding incidents. On the first day of our inspection we requested all incidents of abuse were reported to us. We received some notifications but had to make further requests, of which were partial complied with.

The provider had failed to ensure people were protected from the risk of abuse and avoidable harm. This is a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection, we found the provider had failed to ensure sufficient numbers of suitably competent, skilled and experienced staff were deployed. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18.

● The manager told us they were awaiting three staff to commence employment once their employment checks had been completed. They told us, once these staff were in post the home would be fully staffed. Rotas showed agency staff were still being used but far less than the previous inspection.
● The service had employed an activities co-ordinator since our last inspection, which meant interactions with people had improved.
● We found improvements had been made with the training of staff. We found most staff had completed training the provider had deemed mandatory.

Using medicines safely

At our last inspection we recommended the provider consider current guidance on administering medicines and act to update their practice. The provider had made improvements.

● We found medicines were being managed safely and improvements made. All senior staff had received training in medicines administration, including those staff who worked at night-time. Staff had received allergen training and knew how to access the required medicines in an event of an allergic reaction. The medicines policy in place had been reviewed.
● We observed medicines being administered and found some good practices. For example, explaining to people what their medicines were for and how it would help them.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

At our last inspection the provider had failed to ensure people were well cared for and treated with dignity and respect. This was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 10.

● The service was not caring, and people were not treated with dignity and respect. We checked everyone's bedrooms and found every person had clothing and underwear not belonging to themselves. We mentioned this to the manager on the first day of the inspection. They assured us they had rectified this the same day however, on the second day of inspection and found people still had other people's clothing. People's clothing was not folded neatly away in drawers.
● We found some people did not have any underwear in their drawers. We saw one person whose dignity was affected by the lack of underwear. Those people who did have underwear, this was in a poor state. For example, stained, thread bare or miscoloured. The local safeguarding team had previously requested this was actioned and our last inspection noted this issue. Appropriate action had still not been taken.
● We observed people's hair had not been brushed. However, after discussing this with the manager and activities co-ordinator action was taken. One relative told us, "Mum's hygiene is shocking. She was a very proud lady, but I have found her hair stuck to her head. Mum is not appropriately dressed; I have had issues with [item of underwear]. We have lost count of the number of clothes that has gone missing. She is often wearing other people's clothes." Another relative spoke about being shocked at their loved one's appearance; she was not in her own clothes and her hair was dishevelled.
● The main bathroom was directly off the main lounge and on the second day of inspection, we observed staff had gone in and out when people were having their hair washed. From the lounge there was direct line of vison into the bathroom, compromising people's dignity.
● We observed the lunchtime meal service on both days of the inspection and found a lack of consistent approach to supporting people. Staff stood up when supporting people to eat, rather than sitting down with them, and moved from person to person. We saw one person was not seated at the table properly and therefore found it difficult to reach their food. There was a lack of focus on individuals requiring support, and

this meant people's meals were cold. One person had been given a drink in a specialist cup with the spout facing away from them; this person tried numerous times to drink from the cup without success. The staff were unaware of this until the inspector raised this.

● Staff we spoke with told us the manager was instructing staff to get people up early in the morning when some of them did not want to. We were also advised that care plans had been changed by the manager, to evidence people wanted to get up early when in fact they did not. They also told us; previous care plans reflected they did not like to get up early. We discussed this with the manager, who advised us this was not correct and would forward us the old care plans as evidence no changes had been made by them. We did not receive these.

● One relative told us, "(Name of staff member) is like a breath of fresh air. Very bright, bubbly and interested in people; other staff aren't."

We found no evidence that people had been harmed however, the provider failed to ensure people were well cared for and treated with dignity and respect. This is a continued breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

At our last inspection, the provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The service did not have a registered manager in place at the time of the inspection. There was a manager in place who had been in post since 2 August 2021 and they had submitted an application to register with us. The provider told us changes were also being made to the nominated individual and they would be taking on this role from the end of December 2021. One staff member told us, "The manager is approachable but does not act on concerns raised with her." Another staff told us, "The owners do not listen at all. We barely see them and when we do, they never ask if we have any concerns." One relative spoke about how the home used to be outstanding but that "Things have deteriorated."
● The provider's systems to assess, monitor and improve the quality of the service had not identified the concerns and shortfalls highlighted in this report. People had been subjected to avoidable harm. Not all audits were being completed by the manager, which meant there was a lack of oversight. The manager was unaware of several issues we found on inspection. Records were often incomplete, such as audits, risk assessments and behaviour monitoring records. Records relating to people's care and support needs were not always up to date or reflective of the care being given.
● The service did not promote a positive culture and people did not achieve good outcomes. We have addressed this in the safe and caring domains of this report. Feedback from staff included, "Everyone is unhappy working here. (Manager's name) just sits upstairs. Staff morale is low" and "The staff morale is poor. No one is happy at work. Staff are not well supported by the manager." When asked if staff would be happy for a family member to live in the home, one staff member told us, "Not a chance."
● There was no evidence to show the service was continuously learning and improving. Opportunities to

learn from incidents may have been missed as these had not been fully recorded. We have addressed this in the safe domain of this report.

● Whilst surveys had been sent out to staff, we found two staff had responded with some negative comments. These had not been actioned or analysed to drive improvements. Staff told us there had been a staff meeting in October 2021. However, one staff told us, "(Name of manager) just says 'I will deal with it' when concerns are being raised, but never does." Another staff told us, "We had a staff meeting about two months ago. They are not useful as changes are not made." We also found only three staff had received a supervision since our last inspection. One relative told us they had been involved in a recent meeting which discussed improved activities and decorating but not how the care was improving. Another relative told us, "I have not been asked if we are happy with the care being provided, despite speaking with the manager twice."

● The provider did not always act on the duty of candour. For example, we were not always informed of notifiable incidents which occurred in the home. We had also requested information be sent through to us as part of the inspection on a few occasions which we never received.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service and to keep people safe from avoidable harm. This is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.